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“This Will Not Enter Me”: Painful Anal Intercourse among Black Men Who Have Sex with Men in South African Townships

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Abstract

Little is known about painful receptive anal intercourse (RAI) and its relationship to HIV risk and protective behaviors among men who have sex with men (MSM). The purpose of this study was to identify attributions for and responses to painful RAI among Black MSM in South African townships. In-depth interviews were conducted with 81 Black MSM (ages 20–39 years) who were purposively recruited from four townships. The semi-structured interviews addressed sexual behavior and identity, alcohol use, and safer sex. Pain during RAI was brought up by many participants without specific prompting from the interviewer. Analysis of the interview transcripts revealed that pain was a common feature of first RAI experiences but was not limited to first-time experiences. The participants attributed pain during RAI to partner characteristics, interpersonal dynamics, lack of lubricant, and alcohol use or non-use. The main strategies participants used to address pain during RAI were setting sexual boundaries and lubricant use; a small number of participants reported purposefully consuming alcohol to prevent the pain associated with RAI. Black South African MSM can be supported to reduce pain during RAI in ways that reduce their HIV/STI risk. Culturally-specific sexual health education, supportive sexual health services, and improved access to condom-compatible lubricants are important components of HIV/STI interventions for this population.

Keywords

men who have sex with men; Africa; sexual problems; anal intercourse; lubricant use; sexual orientation; pain

INTRODUCTION

Sexual pain has been studied mainly in the context of heterosexual vaginal sex, and as a consequence, there has been limited study of painful anal intercourse in either women or men (Sandfort & de Keizer, 2001; Štulhofer & Ajdukovi , 2011). Despite some empirical studies of painful sex experiences in samples of men who have sex with men (MSM) in

North America and Europe, and some attention within HIV research among MSM in Africa, our understanding of pain during anal intercourse remains limited, particularly in relation to HIV risk and protective behaviors among MSM. This study presents findings from qualitative research with Black MSM in South Africa; their experiences of and attributions for painful receptive anal intercourse (RAI) are discussed, as are their responses to RAI in terms of HIV risk and protective behaviors.

Pain can occur during anal penetration when the external anal sphincter is not relaxed; because the anus does not self-lubricate, lubricating substances are also needed to reduce pain from friction (Hollows, 2007). Pain however may be a normal part of one's early experiences with RAI. Learning how to safely and comfortably engage in anal sex may be especially challenging for MSM, whose needs within the context of sexual practices are rarely addressed in school-based sex education curricula or by parents (Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010). Other causes of pain during anal penetration may be sexually transmitted infections (STIs) such as herpes, or other anal health issues such as fissures and hemorrhoids (Hollows, 2007).

Experiences of pain during RAI are not uncommon and vary on different dimensions (e.g., frequency, severity). Pain during RAI may be either situational (i.e., related to circumstances such as lack of sufficient foreplay or lubricant) or chronic (Damon & Rosser, 2005). While many men who engage in RAI are able to do so without any pain, a significant portion report at least some experience with painful RAI (Rosser, Metz, Bockting, & Buroker, 1997). In a sample of primarily white, gay-identified men in the U.S., 61% reported ever experiencing painful RAI and 16% indicated that this was a current problem (Rosser et al., 1997). In later studies with demographically similar samples, 24% of participants reported always or nearly always experiencing pain during anal intercourse (Rosser, Short, Thurmes, & Coleman, 1998), and 14% reported frequent and severe pain during RAI (Damon & Rosser, 2005). A more recent study of MSM in Belgium found that 59% reported some degree of pain during and after RAI (Vansintejan, Devroey, & Vandevoorde, 2012).

Among African MSM, pain related to RAI has not been assessed per se; the focus instead has been on related outcomes that are considered indicators of HIV and STI transmission risk. For example, among MSM surveyed in Senegal, 42% reported ever experiencing bleeding and discharge from the anus and 22% reported ever having sores or pimples around the anus (Niang et al., 2003). Sixty percent of MSM surveyed in South Africa reported ever experiencing some form of rectal trauma (hemorrhoids, fissure, or bleeding; Lane, Shade, McIntyre, & Morin, 2008). MSM interview and focus group participants in Ethiopia reported health concerns such as anal bleeding, irritation and tearing, or ulcers around the anus (Gebreyesus & Mariam, 2009). Such symptoms could result from or precede incidents of painful RAI.

In the African context, factors that are unique vulnerabilities for MSM elevate the issue of painful RAI from one of individual to public health significance. Against the backdrop of the criminalization of homosexuality and high HIV prevalence in many African countries, African MSM face substantial barriers in accessing culturally appropriate and competent sexual health care. MSM in South Africa, Senegal, and Kenya have reported prejudice and

harassment from health care workers especially when seeking treatment for rectal infections (Lane, Mogale, Struthers, McIntyre, & Kegeles, 2008; Niang et al., 2003; Okal et al., 2009; Sharma et al., 2008). In some cases this leads men to self-medicate, seek treatment from unqualified health workers, or not be forthright about their symptoms when seeking treatment (Okal et al., 2009). African MSM also have restricted access to condom-compatible lubricants (Baral et al., 2009; Geibel et al., 2008; Geibel, Tun, Tapsoba, & Kellerman, 2010; Henry et al., 2010; Lane, Shade, et al., 2008; Niang et al., 2003; Okal et al., 2009; Wade et al., 2005), which are important tools to prevent painful RAI in addition to being essential HIV/STI prevention tools when used with condoms. Poor access to lubricants and STI treatment may make it harder for MSM to minimize pain during RAI and increase their likelihood of contracting or transmitting HIV and other STIs.

Attributions for and responses to painful RAI among MSM have been assessed in only a few studies. Belgian MSM rated the lack of lubrication and of anal foreplay as the most important factors predicting pain during RAI (Vansintjejan et al., 2012). Participants also reported that prevalence and severity of painful RAI decreased as sexual experience increased (Vansintjejan et al., 2012). Factors such as the lack of lubrication, (insertive partner's) penis size, lack of anal foreplay (for receptive partner), and psychological factors (the example provided is "feeling relaxed") have been endorsed as determinants of pain during RAI in U.S.-based studies (Damon & Rosser, 2005; Rosser et al., 1998). MSM who reported pain that was severe and persistent were more likely than other MSM to attribute their pain to psychological factors, penis size, anal health problems such as hemorrhoids, and not using amyl nitrate ("poppers") or muscle relaxants prior to sex (Damon & Rosser, 2005). Among those who reported persistent and severe painful RAI, 82% said they avoided anal sex for some period of time, 49% said they restricted their behavior to insertive anal intercourse, 31% said a sexual relationship had been disrupted, and 15% said they had limited themselves from finding new sexual relationships (Damon & Rosser, 2005). These findings suggest that pain during RAI can negatively impact sexual health and intimacy in significant ways; relationship factors that might underlie sexual partners' ability to negotiate for foreplay, use of lubricants, and state of mind during sexual encounters could also contribute to the experience of pain. The extent to which African MSM's attributions for and responses to painful RAI would be consistent with these findings is unclear.

The Present Study

Data for this study were from an ethnographic examination of the social organization of same-sex sexual practices and structural and psychosocial correlates of sexual risk behavior among Black MSM in four South African township communities. This ethnographic research, consisting of interviews as well as observations at taverns and with MSM friendship groups, was conducted to lay groundwork for quantitative research with this study population as well as future interventions. Black MSM living in South African townships were the focus of the study given the relative invisibility of MSM in HIV/AIDS research in that setting (Reddy, Sandfort, & Rispel, 2009; South African National AIDS Council, 2007), as well as the overall high prevalence of HIV among Black men in South Africa (23.7 % for Black males aged 25–49 years in 2008; Shisana et al., 2009) and the relationship between HIV/AIDS and poverty (Kalichman et al., 2006).

The research was conducted in four townships in the Tshwane municipality—Atteridgeville, Hammanskraal, Mamelodi, and Soshanguve—located at distances ranging from 12 to 49 kilometers outside of Pretoria’s central business district. Townships are residential areas that were designated for non-whites during the apartheid era; although residential racial segregation ended in 1994, these areas remain almost entirely segregated today. All four of the townships where research was conducted were formerly designated as residential areas for Blacks. According to 2001 census data, Atteridgeville, the township located closest to central Pretoria, was somewhat exceptional for its low percentage of informally housed residents (7 % compared to about 45 % in the other townships) and correspondingly low percentages of households without access to piped water, electricity, or flush toilets (Statistics South Africa, n.d.). Unemployment rates in the townships were about 30 %, although lower in Hammanskraal at 17 % (Statistics South Africa, n.d.). Aside from the realities of the township geography and infrastructure, the daily lives of MSM may be impacted by the limited social acceptance of homosexuality in South Africa, which has implications for their safety and access to health care (Baral et al., 2011; Lane et al., 2008; Rispel, Metcalf, Cloete, Moorman & Reddy, 2011), as well as by the pervasiveness of sexual violence affecting both women and men (Andersson & Ho-Foster, 2008; Jewkes & Abrahams, 2002).

Although not originally an *a priori* focus of our research, many research participants made reference to painful RAI in their discussions of their sexual experiences with men. Given its implications for HIV risk and protective behaviors, as well as for sexual health, pleasure, and relationships more generally, we felt this topic merited closer examination. In the following sections of the article, we present participants’ experiences with painful RAI and consider its role in their decisions about sexual practices.

METHOD

Participants

In-depth interviews were conducted with 81 Black MSM from four township communities (20 participants each from Atteridgeville, Mamelodi, and Soshanguve, and 21 from Hammanskraal). Biological males who self-identified as Black upon screening, were 20–44 years old, resided in one of the four targeted townships, and who reported oral, anal, or masturbatory sex with at least one male in the preceding year were eligible to participate. The final sample consisted of MSM ranging in age from 20 to 39 ($M = 25.16$ years). More than half ($n = 46$) were unemployed or otherwise not earning an income (i.e., students or engaged in unpaid volunteer work). Most participants self-identified as gay (upon being asked, “What words or terms would you use to describe yourself in terms of your sexuality?”); smaller numbers of participants identified as bisexual ($n = 6$), straight ($n = 2$), or did not adopt a label for their sexual identity ($n = 9$). This latter group of participants included those with both bisexual ($n = 6$) and primarily same-sex attractions ($n = 3$). Twenty-five participants reported a lifetime history of sexual experience with women and about half of these participants reported current involvement with female sexual partners. Although we use the term “MSM” to refer to the participants as a group, given the composition of the sample in terms of sexual orientation identification, it is an imperfect

descriptor of the participants' gender identities; seven participants who were biologically male self-identified as transgender women or "drag queens." While not the focus of the present study, the diverse ways in which participants identified and described their sexual and gender identities is described at length in another manuscript (Sandfort, Parker, Gyamerah, Lane, & Reddy, 2013).

Procedure

Candidates for recruitment to in-depth interviews were identified by members of the study's Community Advisory Board, outreach workers at a partnering community-based organization, and by ethnographers in the course of other fieldwork in the townships (e.g., observations at taverns), and then approached about study participation either in person or by phone. Snowball referrals were also made by interview participants. The Project Manager conducted an initial phone screening with each interested candidate, to ensure that he met the study eligibility criteria and to inform the purposive selection of individuals for interviews. Purposive selection of participants was used to ensure that the sample was diverse in terms of age, sexual orientation self-identification, gender presentation, and choice of sexual partners (i.e., exclusively male partners or both male and female partners).

Trained interviewers used a semi-structured guide to conduct interviews that lasted approximately 90 minutes. Interviews were audio-recorded and conducted in private areas at the central Pretoria offices of the collaborating agencies or in a private and secure space in one of the four townships, depending on the participant's preference. The majority of interviews (75%) were conducted in English. As is common among South Africans who live in township communities, discussions were sometimes conducted in more than one language, and most other interviews were conducted in a combination of English and Tswana (Setswana) or Northern Sotho (Sepedi). A few interviews were conducted completely in Tswana or Northern Sotho. All interviews were transcribed in full; passages or complete interviews that were not in English were translated during transcription. The interview guide covered topics such as sexual and gender identity, MSM social networks, family and community acceptance, alcohol and drug use, sexual practices including safer sex behaviors, and experiences with HIV testing.

Analysis

Qualitative data were coded for purposes of this study in two stages, concept-driven and data-driven coding (Gibbs, 2007). First, three coders completed concept-driven coding by independently applying a set of a priori codes to the interview transcripts, using [Atlas.ti](#) software. These concept-driven codes were developed from the study's main research questions and the interview guide; the codebook for interviews was tested on a small batch of transcripts and refinements were made as needed. Initially, each transcript was coded by two coders, who met to reach consensus on the coding and produce reconciled, coded transcripts (37 of the 81 interview transcripts). After consensus about the coding process was reached, the remaining 44 transcripts were coded by one of three coders.

It became clear during the process of concept-driven coding, and upon review of the quotations associated with some of the concept-driven codes (e.g., "First (same-sex)

experiences,” “Experience of same-sex sexuality,” “Sexual practices,” “Unsafe and safer sex practices”), that the participants found several opportunities in the interview to discuss experiences of painful RAI. Painful RAI was often discussed in response to questions about one’s first same-sex sexual experience, negative or unpleasant sexual experiences with men, the effects of alcohol on sexual behavior, and lubricant use. For purposes of this investigation, a second round of data-driven coding was undertaken in order to organize all the material related to painful anal intercourse in consensual sexual encounters. Data-driven coding was completed by the first author and reviewed by a co-author. Codes used included “Pain: First (same-sex) experience,” “Pain: Other than first experience,” “Pain and alcohol use,” and “Knowledge and use of lubricants.” Automatic keyword search functions were used as a supplementary method to identify cases of painful RAI. Experiences of rape or other sexual violence were excluded from this analysis except in one case where painful RAI precipitated a rape (a total of 17 participants disclosed that they were victims of sexual violence).

RESULTS

Clear descriptions of sexual role preferences were provided by 74 of the 81 study participants (the remaining participants did not wish to disclose this information, indicated they did not care for anal intercourse, or had not engaged in anal intercourse). The majority of participants indicated a preference for RAI ($n = 46$), while smaller numbers indicated they preferred insertive AI ($n = 14$) or were “versatile” and would perform both roles ($n = 14$). Of those participants who engaged in RAI because it was their exclusive preference, or because they were versatile, nearly all identified as gay. Most of these participants saw themselves as more feminine than masculine. With the exception of one who did not like anal sex, all the participants who identified as transgender or drag queens also reported a preference for RAI. Descriptions of personal experience with painful RAI therefore come primarily from gay-identified MSM in this study, as the straight-identified MSM and the majority with either a bisexual self-identification or bisexual attractions preferred insertive AI only. Below we first describe participants’ descriptions of pain that occurred during their first same-sex sexual experiences, and then both attributions for and responses to pain that occurred during other experiences of RAI. Table 1 provides a listing and description of all participants who are directly quoted in the following sections.

First same-sex sexual experiences

Participants reported on their first same-sex sexual experiences and how old they were at the time. Sixteen participants indicated that their first same-sex sexual experience occurred before the age of 16; 44 participants were aged 16–19; and 17 had their first experiences after age 20; this data was missing from four respondents. Most participants who were able to recall when they first experienced same-sex attractions reported that they experienced such attractions prior to their first same-sex sexual encounter.

More than three-quarters of participants described first same-sex sexual experiences that involved anal intercourse. Participants commonly described these experiences as painful. A smaller group of men described them as both painful and pleasurable. Another group of

participants, while not referencing pain specifically, used words such as “difficult,” “scary,” and “uncomfortable,” when describing their first sexual encounters with men. Six participants reported that their first same-sex sexual experience, beyond being painful, involved serious anorectal trauma. Four of these participants reported bleeding during or after the encounter, and one reported having hemorrhoids (piles) at the time of first RAI. One participant, Unathi, reported pain that was persistent following the encounter (“Then the following day, I wasn’t able to walk for two weeks...For two weeks I was in pain”). Some of these participants reported that their first sexual experiences were still pleasurable, despite the trauma; bleeding during or after intercourse was also, to some extent, normalized by some participants as something to be expected “when you are having sex as a woman.”

The story shared by Tlotliso exemplified the potential vulnerability of MSM in their first sexual encounters, which could be amplified by the need or desire for secrecy about engaging in same-sex sexual behavior. This participant, who had his first same-sex sexual experience at age 16, described several unexpected consequences, one of which was the disclosure of his sexual behavior to his mother:

We had sex, and after that I put on my clothes and [my sexual partner] accompanied me to my friend’s. When he accompanied me it was Sunday at 7 or 8 in the morning, and when I got to my friend’s house I slept a bit. So around 11 a.m., I felt pain; it was my first time. It was pain from behind. It was painful but I ignored it. The pain alerted me to go to the toilet, I felt like defecating. I went to the toilet and defecated, and as I was busy, blood dripped in the toilet. Afterwards I told my friend, and my friend explained to me what was happening. After some time I felt better and I took a bath and came home; when I got there I told myself that the pain would not happen again.

As Tlotliso goes on to explain, he eventually needed to seek medical intervention:

On Monday, when I went to the toilet again, the same thing happened and my mom was at home. It was painful, I couldn’t close my legs, and she took me to the doctor. When I got there, the doctor told me to climb on the bed and he inspected me and when he was done he told my mother that I am being naughty and that I know what I did and that I will tell her what I did. So my mother asked me what I did and I told her. That’s how my mother found out that I was having sex.

On top of the physical injury he experienced, this participant was shamed by his doctor for “naughty” behaviour (anal sex) and obligated to disclose his same-sex practices to his mother. This quotation illustrates a range of negative outcomes that could possibly have been prevented had Tlotliso received some advance education about how to avoid or address such outcomes.

Attributions for Painful Receptive Anal Intercourse

Participants were asked about subsequent same-sex sexual experiences (i.e., after the first time) in interview questions that addressed, for example, how they felt about having sex with men, how they negotiate what happens during sexual encounters, why they have sex, how they find partners, how HIV could be transmitted, and how they feel about using

condoms and lubricants. Twenty-one participants referred in their interviews to personal experiences with painful RAI, and we focus here on these descriptions. Additional participants made reference to anal sex as painful, though they were not necessarily describing personal experiences (i.e., partners' experiences, general descriptions of why lubricant is used). In analyzing the participant's descriptions of painful RAI, we found that it was attributed to four, sometimes overlapping, factors: partner characteristics (partner's level of same-sex sexual experience; partner's penis size); interpersonal dynamics (certain sexual positions or acts; poor communication or pacing with partner); lack of lubricant; and alcohol use or non-use.

Partner characteristics—The gay-identified men in our sample tended to have more same-sex sexual experience than their bisexual- or straight-identified counterparts. A few of these men attributed their pain or discomfort during sex to their partner's lack of experience with male sex partners. As Lesedi said, "I had an unpleasant [experience] with a person who had no experience with what was going on. It gets difficult because you have to tell him what to do, where to penetrate, what not to do, things like that." Molapo supported this sentiment, describing his first serious relationship with a male partner: "He did not know what happens during sex with other men, and it was quite painful for me when he was penetrating me, it was very uncomfortable, because he was used to having sex with women, so he did not consider that he might be hurting me."

A few participants indicated that the level of pain experienced during RAI was related to their partner's penis size. Thuso (a transgender woman) said she had a negative sexual experience when her partner's penis was larger than she expected: "I thought that he was like having this small thing [penis]...And then [after seeing it] I thought, 'Oh my God, what have I got myself into?'" As Tlotliso summed it up: "If [his penis is] big it will be painful, if it's medium then it won't be painful, and if it's small, it won't be painful. If it's too big, I will feel pain and may bleed; sometimes it's difficult to go to the toilet."

Interpersonal dynamics—Participants described other attributions for painful RAI that seemed to arise during the sex act: positions or encounters that were uncomfortable, encounters that did not go as planned, partners whose desires did not align with their own. Dingani, for example, described having to resist requests to engage in behaviors that had caused him pain in the past, like having sex in the rear-entry position, or having anal sex again in the morning after having it the night before (described colloquially by him as "morning glory"). He explained, "I've had doggy style once and while we were busy I could feel – I don't know if the same thing happens to women...I could feel pain by my navel... The penis felt like it was in my stomach."

Several participants reported experiencing pain as a result of anal intercourse that, although consensual, was either too rough, too fast, or too slow. In their descriptions of these encounters, some men mentioned that lack of lubricant or alcohol consumption (which seemed to delay their partner's ejaculation) contributed to the pacing or the rough quality of the sex, as did their partner's relatively greater control over the situation or refusal to listen to their wishes. Sizwe shared the following story about a negative sexual experience:

I had this guy, a friend of mine, we didn't use lubricants, so it was painful. I didn't sleep with him ever again, I just slept with him twice. But he was my boyfriend, my steady boyfriend, so like I had to just, you know, end the relationship because of that sex."

Interviewer: Okay, what was painful about the sex?

He was so rough, and then like he didn't listen to what I wanted in bed. He was so controlling to me and he wanted whatever he wanted.

Lutendo and Tumelo shared similar accounts. Lutendo spoke generally of partners who "want something to happen on their time, never mind how painful that thing is as long as he is satisfied." Tumelo told of a partner controlling a sexual encounter with little regard for his comfort or pleasure:

The experience, that person he controlled me over and he was just doing it and he was rushed, he was rough and rushed. That's why I've experienced a lot of pain and stayed for a long time not having sex.

Interviewer: Was it something that you felt needed to be reported?

No, it's just that I felt that I must tell him that I didn't like what he did.

Interviewer: And did you tell him?

Ja, I did tell him that 'next time you must be gentle and I've told you that before we have sex, that you must be gentle, but you didn't make it, you're just being rushed and now I am experiencing the pains.

Lack of lubricant—Many participants said that RAI was painful, or would lead to bleeding and tearing of the anal tissue (often described as "cracks"), in instances when lubricant was not used. Interviewers generally did not probe for specifics about the type of lubricants referred to in these instances, however. Fenyang said that RAI could lead to "health issues" such as hemorrhoids (piles) and tearing among "gay guys who do not know how to use lubricants." In explaining the importance of using lubricant with condoms, Tlotliso said, "Condoms are oily, but I also have to put some lubricant on because I will feel pain if I don't." Dikeledi (who identified as a drag queen), when asked if she had ever had any negative sexual experiences, cited an instance when she did not use lubricant: "It was dry and he was forcing, so I felt pain." In this case, both the lack of lubrication and the interpersonal dynamics may have contributed to the experience of pain – suggesting that, as in some of the previous examples, attributions for painful RAI were overlapping.

Although it was the lack of lubricant in the context of sexual encounters that participants discussed in relation to painful RAI, participants also commented more generally on the limited availability of lubricants in their townships. Unlike condoms, which were widely available for free, lubricants generally needed to be purchased at venues located outside the townships (such as pharmacies and adult shops). Pharmacy costs for a 50 ml tube of lubricant can range from about 50–75 rands (\$4.50–7.00 US).

Alcohol consumption—Participants linked alcohol consumption to painful RAI in several ways. A few attributed painful RAI to their own use or non-use of alcohol, while others said that it was their insertive partner's drinking that made certain encounters painful. RAI was painful to some participants when they were sober, and was less painful when they were drunk. Shandu said, "When I am sober, I feel the sex pain. When I'm drunk I don't feel it." However, for others, there were also negative consequences to being drunk while engaging in RAI. As Dingani explained, in describing how sex differed whether he was sober or drunk:

When you are sober it's different because you can see everything that you are doing. When a guy is too rough, you can feel the pain and ask him to stop. When you are drunk everything goes, but that does not happen with me; if I don't want something then I don't want it, but as for a guy being rough or how he put it in, it doesn't matter. Sometimes you find that I ask the guy to come closer because I can't feel him.

As Tumelo explained, when describing how drinking affected his sexual behavior, the numbing effect of alcohol during a sexual encounter could sometimes have consequences later:

Sometimes you forget to use a condom or sometimes you forget to use a lubricant, because if you are under influence of alcohol you can't feel the pains mostly. You feel them tomorrow.

This quotation again illustrates that there could be multiple, mutually reinforcing reasons for painful RAI (forgetting to use lubricant as a result of alcohol intoxication). Finally, a few participants noted that RAI could be painful when their partners were drunk, either because they would have difficulty reaching a climax or became more aggressive. Zithembe explained the effect of drinking on men's sexual behavior as follows: "If he drank a lot, like low erection or sometimes he gets fully erected, he doesn't come easily and you get yourself irritated; you can't take it anymore."

Responses to Painful Receptive Anal Intercourse

In analyzing participants' responses to painful RAI, two themes emerged, representing two related strategies that participants used to prevent pain either in anticipation of anal intercourse or in-the-moment: *setting sexual boundaries* and *lubricant use*. These strategies are discussed in further detail below. A small number of participants used strategies that would not fall into either of these categories. For example, although a larger number of participants had generally discussed alcohol use as a context for painful RAI, two participants reported using alcohol purposefully to prevent the pain associated with RAI. Despite the small number of participants who reported this practice, it is important to mention because of its potential significance in HIV/STI transmission.

Setting sexual boundaries—Several participants described setting personal boundaries regarding what they would and would not do sexually as a response to experiences of painful RAI and to avoid anal pain. These actions included abstaining from anal intercourse; having non-penetrative sex; and having rules about sex acts or sexual positions one would or

would not perform. Dingani explained how he would communicate his boundaries to his sexual partners:

Interviewer: When you are having sex do you negotiate what type of sex you want and do you also give the other person a chance to voice what he wants?

Yes, we talk about it first. I tell him what I like; I tell him I like frozen ('like a chicken') and other positions.

Interviewer: You speak about frozen; which other positions do you negotiate?

Some of them I don't know their names, they just happen, even on the chair. There was this other book that had the names but I didn't read it too much. I also give him a chance to tell me what he wants, and if ever he wants doggy style I will tell him I can't, and if he says he will be gentle I tell him that either way it's painful. So I will tell him to think of something. If he can't, I will tell him to sleep.

In Dingani's description, setting boundaries involves negotiation with a partner willing to respect his wishes. Kabelo described a similar negotiation process, explaining that he would make assessments about what type of sex to engage in on a case-by-case basis:

Interviewer: When you are with a man would it be clear from the start what type of sex you will have and how is it clear what type of sex you will be having?

"It depends how big it is."

Interviewer: How big it is...?

"he penis. And you tell yourself, 'this will not enter me,' and to avoid that you negotiate and you tell him you want thigh sex or whatever. But sometimes it's big but he is gentle and we use lubricants and he can penetrate you and there is no pain. It depends on the guy, whether he is rough or gentle. If he is rough, you can tell him that he is too rough and you can try a second option.

Interviewer: And most of the time they agree?

Yes, they agree.

The above example illustrates that boundary-setting might happen not only case-by-case, but from moment to moment, as needed to ensure a pleasurable sexual experience. This example also illuminates the overlapping factors that could structure the experience: the insertive partner's penis size and approach to sexual intimacy (rough or gentle), as well as the presence or absence of lubricant. Some participants set sexual boundaries specifically related to lubricant use, saying that they would not engage in anal intercourse if lubricant was not available. As Kabelo also explained:

Sometimes it happens that you hang out with friends and you meet with someone and you start kissing and it happens that you forgot the lubricant and the guy wants to have sex without the lubricant and I tell the guy I don't want something like that.

Interviewer: Have they done it by force to you without lubricant?

No, normally the guy wants to do it but I say no and I tell them I don't like this and this.

Sexual boundaries were not always respected, however, particularly from sexually abusive partners. For example, Mosegi described how what began as a consensual sexual encounter ended in rape when he withdrew consent during an attempt at intercourse that was painful:

Some other guy, we agreed to each other, we went to his place and then he was beating me because, how can I put it?...I can say his dick was very huge. He could not like penetrate it to me. And then he was busy like trying to force himself on me.

Interviewer: And so why did he end up beating you up?

Because I was telling him he could not enter me...He started to beat me and hit me with a bottle...I was scared of him...He tried to force himself on me. And then I was like, I became relaxed anyway for him to do his job.

Lubricant use—The majority of participants indicated that they regularly used lubricants during anal intercourse to make penetration easier and reduce pain. As Masopha explained,

I would say to gays, the lubricants are the best things since sliced bread. Like initially the sex was painful and like it was unbearable, and there were cuts and there was this and there was this. But because of the lube, then the sex it is more easy and bearable I think.

Use of commercially available water-based lubricants such as KY Jelly, Durex Play, and Assegai, was most commonly reported. Some participants reported using oil-based lubricants such as jojoba or baby oil and Vaseline; Remicaïne gel (which contains lidocaine); plain yogurt; and saliva. For Lesedi, such alternative lubricants were used when commercial lubricants were unavailable: “In the case where you do not have KY gel you are going to use lotion because you don’t want to have those cracks, because penetration is painful sometimes.”

Pain reduction and heightened sexual pleasure were cited as reasons why it was important to use lubricants with condoms. Most participants understood the importance of water-based lubricants as an HIV risk reduction tool when used alongside latex condoms, explaining that lubricants decreased friction and reduced the likelihood of condom breakage. “I think having anal sex...you have to be wet so that the condom will not burst and that your sex is comforting,” said Tsie. Mareka also referred to the ability of lubricants to both increase comfort during RAI and prevent condom failure: “The thing is with lubricants...it eases the muscles as well and the tightness of it; it prevents more friction while using a condom. Because I have experienced that the condom—it breaks when you are not using lubrication.”

DISCUSSION

The findings of this study demonstrate that painful RAI is an important health concern for Black MSM in South Africa who engaged in RAI. Participants attributed painful RAI to various factors and coped with it in different ways, but there were some clear commonalities in their descriptions. The ways in which these men are already coping with this issue also suggest several opportunities for effective sexual health and HIV prevention educational interventions. MSM who engage in RAI are clearly motivated to reduce pain during RAI; they can be supported to do so in ways that may also reduce their HIV/STI risk. Addressing

some of the participants' attributions for painful RAI, such as interpersonal power dynamics in sexual situations, lack of lubricant, and alcohol use, is likely to be beneficial in terms of lowering their risks for HIV/STI transmission. Their responses to painful RAI can also be optimized so that they yield the greatest health benefits (i.e., education about lubricants that are condom compatible and alternatives when commercial lubricants are not available).

The qualitative nature of this study provides more nuanced information about some issues that have been raised in the few previous studies of painful RAI. For example, while (lack of) sexual experience has been found to be a determinant of painful RAI for some men (Rosser, Short, Thurmes, & Coleman, 1998), we found that the experience differential between sexual partners was also important. Among this study's participants, men who preferred the receptive role in anal intercourse (most of the gay-identified participants in this sample) tended to have more same-sex sexual experience than men who preferred the insertive role (and who were primarily the non-gay-identified participants in this sample). This experience differential in some cases led to intercourse that was painful for the receptive partner. MSM engaging in RAI therefore may have an important role as far as expressing their preferences to partners during anal sex; many were quite capable of articulating their likes and dislikes to the study interviewers and could potentially be empowered to do the same during sexual encounters. However, further study of same-sex sexual partnerships in this context is needed so that we have a more complete understanding of the factors that shape how MSM communicate about what feels good and what doesn't, and how partners listen to one another, during sexual encounters. Gendered power dynamics appear to play an important role, but further study is needed to better understand the way in which such dynamics shape sexual encounters and relationships.

Although we make comparisons to other studies with some caution, given that participants in this study were not asked directly about painful RAI, we note that no participants in this study reported limiting their behavior to insertive anal intercourse in response to pain in the receptive role, although this has been found among MSM in the U.S. (Damon & Rosser, 2005). Most participants in this study reported exclusive preference for either the insertive or receptive role, and their sexual role preferences were strongly linked to sexual identity and gender expression (Sandfort, Parker, Gyamerah, Lane, & Reddy, 2012). Perhaps some Black South African MSM are unlikely to switch their sexual roles to manage sexual pain given the importance of sexual role to overall sexual and gender identity. A few studies have considered the relationship between sexual role preferences and gender expression in MSM (e.g., Rabie & Lesch, 2009; Zheng, Hart, & Zheng, 2012), and further study of these issues could shed light on the gender and power dynamics between sexual partners that might influence communication and experiences of pain and pleasure during anal intercourse.

We also note that, whereas drugs such as amyl nitrate ("poppers") have reportedly been used by MSM in the U.S. to manage painful RAI (Damon & Rosser, 2005), in this study we heard men discuss the importance of alcohol use to alleviate pain during anal intercourse. The emphasis on alcohol use makes sense given the accepting cultural norms in South African townships with regard to alcohol consumption, and the fact that venues serving alcohol are some of the few places where MSM in the townships congregate and meet sexual partners (Lane, Mogale, Struthers, McIntyre & Morin, 2007; Reddy et al., 2012; Tshabalala, Lane,

Parker, Reddy, & Sandfort, 2012). Alcohol use has been associated with unprotected sex in other studies with South African MSM (Lane, Shade et al., 2008), and thus understanding the links between painful RAI, alcohol use, and unprotected sex is crucial to HIV prevention efforts for this population.

Several strengths and limitations of this study should be noted. Given the sampling approach, the participants in this study are not necessarily representative of Black South African MSM, and findings are not generalizable to other populations of MSM. One of the study's strengths is the inclusion of participants who were diverse with regard to sexual orientation self-identification, gender expression, and sexual practices. However, more feminine, gay-identifying MSM were best represented in the sample and it was their voices that were dominant on the issue of painful RAI; the perspectives of MSM engaging in insertive AI should be solicited as part of future studies of this topic. There are some additional limitations inherent in the method of assessment and the assessments that were utilized. Direct questions about pain during anal intercourse were not part of the interview guide used in this study, and interviewers did not have specific guidance on how to probe when participants raised this issue themselves. The participants' experiences with painful RAI were therefore not systematically assessed, and the way they were reported could be have been affected by factors such as the participants' comfort with their own sexual identity and behavior, their experiences with or perceptions of homophobia, comfort with the face-to-face interview setting more generally, as well as each interviewer's skill in eliciting information about sexual practices. We are also lacking information on some aspects of the participants' experiences that might be important, such as whether pain was ever severe enough that RAI had to be discontinued, whether they experienced emotional distress or relationship difficulties as a result of the physical pain they experienced, and how experiences of pain may have been related to sexual pleasure in general or to past experiences of sexual violence. Despite these limitations, the fact that participants in this study discussed painful RAI in relation to sexual practices and decisions without direct questioning by the study interviewers, further suggests it is an issue that many MSM prioritize.

Our findings highlight some of the structural conditions affecting Black South African MSM: a lack of targeted sexual health education, limited access to sexual health care and safer sex supplies, and a limited number of community spaces in which to socialize with other MSM. One way to address these conditions is with targeted sexual health education and services. First, MSM should be better prepared for their first same-sex sexual experiences. As has been shown in other studies, the lack of formal sex education resources targeted to MSM may lead them to alternative sources of information, such as sexual partners, MSM peers, web-based resources, and pornography (Kubicek et al., 2010). In South African townships, where gay community spaces are non-existent (Osmand et al., 2012; Reddy et al., 2012), access even to informal sources of MSM-specific sex education is likely to be limited. Yet the fact that many participants in this study recognized their same-sex attractions well before engaging in any same-sex sexual behavior suggests that there is an opportunity to deliver the relevant information before men first engage in anal intercourse. Many participants in this study also reported same-sex sexual debut after the age of 16, which is the median age of sexual debut for South African men (Pettifor et al.,

2005), and which suggests a window of opportunity for relevant sex education in middle adolescence. Addressing the specific information needs of MSM within the context of sex education in adolescence, and through outreach work and network building, can assist them in planning for sexual experiences with fewer negative consequences. Discussion of anal sex within sex education programming for adolescents is further warranted by its potential significance in HIV transmission among heterosexuals in South Africa (Kalichman, 2009); painful RAI can occur in the context of heterosexual sexual encounters, as well.

Additionally, the participants' attributions for and responses to painful RAI suggest several messages that should be incorporated into targeted health programming for MSM: the importance of using both condoms and condom-compatible lubricants when engaging in anal sex; how alcohol and other substance use may affect one's threshold for pain, as well as one's ability to consistently and correctly use condoms and lubricant; the relative risk of anal sex versus other sexual behaviors; and how to recognize STI symptoms. Education regarding effective communication techniques in the context of sexual relationships is also important. Participants who were able to exert or share control in sexual situations were best able to avoid the experience of painful RAI. Health education messaging that is tailored to MSM's sexual role preferences may be appropriate and should engage *all* men who have anal sex with other men. Gay-identified men may be the most visible among MSM in South African townships, and consequently the easiest to engage, and yet it will not be sufficient to engage these men alone.

MSM should be supported in adopting those responses to painful RAI that also reduce their HIV/STI risk. The participants in this study reported that while condoms are widely available (for purchase or for free), lubricants are more difficult to obtain, as they are offered in fewer places and are only rarely made available for free. The cost of commercial lubricants to the participants in our study, many of whom were unemployed, was considered expensive. These concerns were echoed by key informants (e.g., service providers) who participated in another component of the study. There are also a limited number of places to which MSM can be referred for sexual health care (e.g., for treatment of rectal STI infections) with the assurance that they will be treated respectfully. Efforts to capacitate local service providers and community-based organizations to address the sexual health needs of MSM will therefore be essential. Capacitating health care workers should include skills-building around non-stigmatizing clinical care of MSM and strengthening practices around patient confidentiality to avoid, among other things, involuntary disclosure of same-sex sexual behaviors or sexual minority identity. Efforts are underway to address these issues, by organizations such as OUT Well-being in Tshwane and Anova Health Institute's Health 4 Men initiative in Cape Town and Johannesburg, and these activities should be expanded so that a broader group of MSM may benefit.

This study's findings shed light on an issue that has received little research attention in the field of gay men's or MSM health. A more systematic study of experiences with painful RAI and how those experiences motivate sexual decision making is warranted, and may be relevant to the development of new HIV prevention technologies such as rectal microbicides (see for example, Clark et al., 2012). Putting the spotlight on this issue may yield added and

renewed health and wellness benefits to individual men, but is also potentially an important part of HIV and STI prevention efforts focused on this population.

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REFERENCES

- Andersson N, Ho-Foster A. 13,915 reasons for equity in sexual offences legislation: A national school-based survey in South Africa. *International Journal for Equity in Health*. 2008; 7:20. [PubMed: 18664250]
- Baral S, Burrell E, Scheibe A, Brown B, Beyrer C, Bekker L. HIV risk and associations of HIV infection among men who have sex with men in peri-urban Cape Town, South Africa. *BMC Public Health*. 2011; 11:766. [PubMed: 21975248]
- Baral S, Trapence G, Motimedi F, Umar E, Iipinge S, Dausab F, Beyrer C. HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS One*. 2009; 4:e4997. [PubMed: 19325707]
- Clark JL, Salvatierra HJ, Segura ER, Salazar X, Konda K, Galea J, Caceres CF. Frequency, patterns, and preferences of lubricant use during anal intercourse within male sexual partnerships in Lima, Peru: Implications for a rectal microbicide HIV prevention intervention. *AIDS Care*. 2013; 25:579–585. [PubMed: 23082796]
- Damon W, Rosser BRS. Anodyspareunia in men who have sex with men: Prevalence, predictors, consequences and the development of DSM diagnostic criteria. *Journal of Sex & Marital Therapy*. 2005; 31:129–141. [PubMed: 15859372]
- Gebreyesus SH, Mariam DH. Assessment of HIV/AIDS-related risks among men having sex with men (MSM) in Addis Ababa, Ethiopia. *Journal of Public Health Policy*. 2009; 30:269–279. [PubMed: 19806068]
- Geibel S, Luchters S, King'ola N, Esu-Williams E, Rinyiru A, Tun W. Factors associated with self-reported unprotected anal sex among male sex workers in Mombasa, Kenya. *Sexually Transmitted Diseases*. 2008; 35:746–752. [PubMed: 18650772]
- Geibel S, Tun W, Tapsoba P, Kellerman S. HIV vulnerability of men who have sex with men in developing countries: Horizons Studies, 2001–2008. *Public Health Reports*. 2010; 125:316–324. [PubMed: 20297760]
- Gibbs, G. Analyzing qualitative data. Los Angeles, CA: Sage; 2007.
- Henry E, Marcellin F, Yomb Y, Fugon L, Nemande S, Gueboguo C, Spire B. Factors associated with unprotected anal intercourse among men who have sex with men in Douala, Cameroon. *Sexually Transmitted Infections*. 2010; 86:136–140. [PubMed: 19703845]
- Hollows K. Anodyspareunia: a novel sexual dysfunction? An exploration into anal sexuality. *Sexual and Relationship Therapy*. 2007; 22:429–443.
- Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science & Medicine*. 2002; 55:1231–1244. [PubMed: 12365533]
- Kalichman SC, Simbayi LC, Cain D, Jooste S. Heterosexual anal intercourse among community and clinical settings in Cape Town, South Africa. *Sexually Transmitted Infections*. 2009; 85:411–415. [PubMed: 19429569]
- Kalichman SC, Simbayi LC, Kagee A, Toefy Y, Jooste S, Cain D, Cherry C. Associations of poverty, substance use, and HIV transmission risk behaviors in three South African communities. *Social Science & Medicine*. 2006; 62:1641–1649. [PubMed: 16213078]

- Kubicek K, Beyer WJ, Weiss G, Iverson E, Kipke MD. In the dark: Young men's stories of sexual initiation in the absence of relevant sexual health information. *Health Education & Behavior*. 2010; 37:243–263. [PubMed: 19574587]
- Lane T, Mogale T, Struthers H, McIntyre J, Kegeles SM. "They see you as a different thing": The experiences of men who have sex with men with healthcare workers in South African township communities. *Sexually Transmitted Infections*. 2008; 84:430–433. [PubMed: 19028941]
- Lane, T.; Mogale, T.; Struthers, H.; McIntyre, J.; Morin, S. Alcohol and high-risk sex in South African township MSM communities; Poster session presented at the South African AIDS Conference; Durban, South Africa. 2007 Jun.
- Lane T, Shade SB, McIntyre J, Morin SF. Alcohol and sexual risk behavior among men who have sex with men in South African township communities. *AIDS and Behavior*. 2008; 12:S78–S85. [PubMed: 18392672]
- Niang CI, Tapsoba P, Weiss E, Diagne M, Niang Y, Moreau AM, Castle C. 'It's raining stones': stigma, violence and HIV vulnerability among men who have sex with men in Dakar, Senegal. *Culture, Health & Sexuality*. 2003; 5:499–512.
- Okal J, Luchters S, Geibel S, Chersich MF, Lango D, Temmerman M. Social context, sexual risk perceptions and stigma: HIV vulnerability among male sex workers in Mombasa, Kenya. *Culture, Health & Sexuality*. 2009; 11:811–826.
- Osmand, T.; Lwana, M.; Sandfort, T.; Mantell, J.; Dunkle, K.; Kegeles, S.; Struthers, H.; McIntyre, J.; Lane, T. "One day we will come together and unite": Imagining community among men who have sex with men (MSM) in Mpumalanga, South Africa; Poster session presented at the International AIDS Conference; Washington, DC. 2012 Jul.
- Pettifor AE, Rees HV, Kleinschmidt I, Steffenson AE, MacPhail C, Hlongwa-Madikizela L, Padian NS. Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey. *AIDS*. 2005; 19:1525–1534. [PubMed: 16135907]
- Rabie F, Lesch E. 'I am like a woman': Constructions of sexuality among gay men in a low-income South African community. *Culture, Health & Sexuality*. 2009; 11:717–729.
- Reddy, V.; Salo, E.; Morison, T.; Botsis, H.; Baloyi, A.; Mtshengu, A.; Sandfort, T. Taverns, bars and shebeens: Sexual risk and HIV within homosocial spaces among Black men who have sex with men in South African townships; Poster session presented at the International AIDS Conference; Washington, DC. 2012 Jul.
- Reddy, V.; Sandfort, T.; Rispel, L., editors. From social silence to social science: Same-sex sexuality, HIV & AIDS and gender in South Africa. Cape Town, South Africa: HSRC Press; 2009.
- Rispel LC, Metcalf CA, Cloete A, Moorman J, Reddy V. You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in South African cities. *Journal of Public Health Policy*. 2011; 32:S132–S151.
- Rosser BRS, Metz ME, Bockting WO, Buroker T. Sexual difficulties, concerns, and satisfaction in homosexual men: An empirical study with implications for HIV prevention. *Journal of Sex & Marital Therapy*. 1997; 23:61–73. [PubMed: 9094037]
- Rosser BRS, Short BJ, Thurmes PJ, Coleman E. Anodyspareunia, the unacknowledged sexual dysfunction: A validation study of painful receptive anal intercourse and its psychosexual concomitants in homosexual men. *Journal of Sex & Marital Therapy*. 1998; 24:281–292. [PubMed: 9805288]
- Sandfort TGM, de Keizer M. Sexual problems in gay men: An overview of empirical research. *Annual Review of Sex Research*. 2001; 12:93–120.
- Sandfort, T.; Parker, R.; Gyamerah, A.; Lane, T.; Reddy, V. After-nine, 429, he-she, stabane, and gay, bisexual and other 'men sleeping with men': Diversity in Black South African MSM identities and implications for HIV prevention; Poster session presented at the International AIDS Conference; Washington, DC. 2012 Jul.
- Sandfort T, Parker R, Gyamerah A, Lane T, Reddy V. Sexual identity, gender, and sexual practices in South African men who have sex with men. 2013 Manuscript in preparation.
- Sharma A, Buklisi E, Gorbach P, Cohen CR, Muga C, Kwena Z, Holmes KK. Sexual identity and risk of HIV/STI among men who have sex with men in Nairobi. *Sexually Transmitted Diseases*. 2008; 35:352–354. [PubMed: 18360318]

- Shisana, O.; Rehle, T.; Simbayi, L.C.; Zuma, K.; Jooste, S.; Pillay-van-Wyk, V. The SABSSM III Implementation Team. South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?. Cape Town: HSRC Press; 2009.
- South African National AIDS Council. HIV and AIDS and STI Strategic Plan for South Africa, 2007–2011. 2007. Retrieved from <http://www.doh.gov.za/list.php?type=HIV%20and%20AIDS&year=2007>.
- Statistics South Africa. Census 2001. (n.d.) [interactive and electronic products]. Retrieved from www.statssa.gov.za
- Štulhofer A, Ajdukovi D. Should we take anodyspareunia seriously? A descriptive analysis of pain during receptive anal intercourse in young heterosexual women. *Journal of Sex & Marital Therapy*. 2011; 37:346–358. [PubMed: 21961443]
- Tshabalala, X.; Lane, T.; Parker, R.; Reddy, V.; Sandfort, T. Alcohol and the social scripting of unsafe sex among Black men who have sex with men in South African townships; Poster session presented at the International AIDS Conference; Washington, DC. 2012 Jul.
- Vansintjean J, Devroey D, Vandevoorde J. The Gay Men Sex Studies: Anodyspareunia among Belgian Gay Men. *Journal of Sexual Medicine*. 2012; 9:227.
- Wade AS, Kane CT, Diallo PAN, Diop AK, Gueye K, Mboup S, Lagarde E. HIV infection and sexually transmitted infections among men who have sex with men in Senegal. *AIDS*. 2005; 19:2133–2140. [PubMed: 16284463]
- Zheng L, Hart TA, Zheng Y. The relationship between intercourse preference positions and personality traits among gay men in China. *Archives of Sexual Behavior*. 2012; 41:683–689. [PubMed: 21837518]

Table 1

Characteristics of Study Participants Pseudonym

Pseudonym	Age	Residence	Socioeconomic status ^a	Sexual orientation identity	Gender identity/expression	Sexual role preference
Dikeledi	28	Soshanguve	Unemployed	Does not use a self-label other than “drag queen”; attracted to men only	Drag queen; feminine	Receptive
Dingani	22	Hammanskraal	Unemployed	Gay	Feminine	Receptive
Fenyang	28	Atteridgeville	Unemployed	Gay	Feminine	Receptive
Kabelo	39	Atteridgeville	Earns R4501–R8000 per month	Gay	Masculine	Is versatile but prefers receptive role
Lesedi	24	Soshanguve	Unemployed	Homosexual/gay	Both masculine and feminine, but more feminine	Versatile
Lutendo	20	Hammanskraal	Unemployed	Gay	Feminine	Receptive
Mareka	23	Atteridgeville	Student	Did not wish to identify; reported exclusive attraction to men	Feminine	Receptive
Masopha	29	Mamelodi	Earns R1501–R4500 per month	Gay	Both masculine and feminine	Unknown
Molapo	22	Soshanguve	Earns R4501–R8000 per month	Gay	Feminine	Receptive
Mosegi	22	Mamelodi	Working part-time; income not provided	Attracted to men only but sexual orientation identity not ascertained	Feminine	Receptive
Shandu	20	Mamelodi	Unemployed	Gay	Feminine	Receptive
Sizwe	25	Hammanskraal	Unemployed	Gay	Feminine	Receptive
Thuso	30	Soshanguve	Unemployed	Gay	Drag queen or “she male” who is undergoing hormone therapy and plans to make a surgical gender transition	Receptive
Tlotliso	21	Soshanguve	Unemployed	Homosexual	Feminine	Receptive
Tsie	22	Atteridgeville	Earns R1501–R4500 per month	Gay	Feminine	Receptive
Tumelo	20	Hammanskraal	Unemployed	Attracted to men only; sexual orientation identity not ascertained	Masculine	Receptive
Unathi	21	Hammanskraal	Student	Gay	Feminine	Receptive
Zithembe	27	Mamelodi	Earns R4501–R8000 per month	Gay	Feminine	Receptive

Note. Of all 81 study participants, only those quoted in the text are included in this table.

^aIncome ranges of R1501–R4500 are equivalent to approximately US \$137–410. Income ranges of R4501–R8000 are equivalent to approximately US \$410–730.